Coding for Hybrid TEVAR

A case study in coding protocol for a unique thoracic aneurysm repair.

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The procedure described in the Challenging Case on page 24 by Deaton et al is challenging from a coding perspective due to the location of the aneurysms and the repair technique. This column presents the coding recommendations for such a case. Table 1 lists some important points to be considered in coding similar cases.

PROCEDURE SYNOPSIS

The right femoral artery was exposed and a sheath was placed. Percutaneous left femoral access was established. A median sternotomy was made, and the ascending aorta and arch vessels were dissected. A trifurcated vascular graft was customized by adding an additional length of graft (pointing the opposite direction from the trifurcation) to be used as a conduit for placement of the endoprosthesis. This graft was anastomosed end to side to the ascending aorta. The innominate artery, left common carotid, and left subclavian were transected, and the proximal stumps were oversewn. The three arch vessels were then anastomosed to the three limbs of the trifurcated graft. An incision was made in the right abdominal wall, and a subcutaneous tunnel was created between the abdomen and the mediastinum. The additional limb that had been added to the trifurcated graft was brought out through this tunnel and secured to the abdominal skin. Via this conduit, an intravascular ultrasound catheter was passed and used to examine the aorta. Then, the Gore TAG endoprosthesis (Gore & Associates, Flagstaff, AZ) was advanced through the conduit and passed antegradely through the arch and down into the distal descending thoracic aorta. A second endograft was deployed proximal to the first, followed by a third endograft that landed just distal to the ascending aortic graft. The graft was then ballooned. The conduit was ligated at the level of the aortic graft and oversewn.

RECOMMENDED CODES

37799 – Unlisted procedure, vascular surgery
76496-26 – Unlisted fluoroscopic procedure (eg, diagnostic, interventional)
35626-22 – Bypass graft, with other than vein; aortosubclavian or carotid
34812-RT – Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral
36200-50 – Introduction of catheter, aorta (bilateral, from right femoral access and also via the conduit)
36140-59 – Introduction of needle or intracatheter; extremity artery (left femoral access)
37250 – Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (list separately in addition to code for primary procedure)
75945-26 – Intravascular ultrasound (noncoronary vessel), radiologic supervision and interpretation; initial vessel

COMMENTS

There are CPT codes for endovascular repair of the descending thoracic aorta. However, this case involved placement of endoprostheses extending from the ascending aorta, through the arch, and into the descending thoracic aorta. Endovascular repair of the ascending aorta and aortic arch must be reported with the CPT unlisted

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TABLE 1. CODING TIPS

- Endovascular repair of the ascending aorta and aortic arch is reported as an unlisted procedure. The codes for endovascular repair of the descending aorta (33880-33881) should not be used for this procedure.

- Arterial exposure is separately reportable and is eligible for cosurgery reimbursement.

- Catheter placements and intravascular ultrasound are separately reportable and are not eligible for cosurgery reimbursement.

procedure codes. In this case, code 37799 is used to report the surgical component of the repair, and code 76496 is used to report the imaging supervision and interpretation.

When unlisted procedure codes are reported on the claim, it is necessary to provide the payor with a description of the procedure (a copy of the procedure note and/or a letter of explanation). It is also advisable to indicate similar procedures on which the payor can base the reimbursement. In this case, the unlisted procedure includes work similar to codes 33880, 75956, and 34833 (for creation of the conduit).

Because the second and third prostheses were placed in an antegrade fashion, the procedure is more similar to placement of distal prostheses, which is not separately reportable, rather than proximal prostheses, which are reported with codes 33883, 33884, and 75958.

The bypass between the ascending aorta and the arch vessels is reported with code 35626. Modifier 22, unusual procedural service, is applied to reflect the fact that three separate vessels were anastomosed to the graft.

Three different catheterization codes are reported to represent the three separate accesses: right femoral cutdown, percutaneous left femoral, and the conduit to the ascending aorta.

As with any procedure performed by cosurgeons, portions of the procedure that were performed jointly should be reported by each physician with modifier 62, indicating two surgeons. The surgical component of endovascular repair of the aorta is recognized by most payors as eligible for cosurgery payment. Imaging component services and catheter placements are not eligible for cosurgery reimbursement and should be reported by only one physician. ◼

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